

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-013185

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

FILED APR 8 1963

Primary Registration District No.

1003

Registrar's No.

3611

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

D.E. Cozart, M.D.
USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN St. Louis, Mo.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. # 1		d. STREET ADDRESS 2633 Lucas	
3. NAME OF DECEASED (Type or print) CLARENCE		4. DATE OF DEATH MARCH 12 1963	
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-23-89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AAA Recipient		11. BIRTHPLACE (City and state or country) Kentucky	
13a. FATHER'S NAME Doc		13b. MOTHER'S MAIDEN NAME Amanda Gibson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Not known		17. INFORMANT St. Louis City Hospital 1515 Lafayette	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO (b) Thrombophlebitis left leg DUE TO (c) 463X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchopneumonia, Cirrhosis of liver.		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 2/20/63 to 3/12/63 and last saw her alive on 3/12/63 Death occurred at 3:06 A M on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE D.E. Cozart M.D.		22b. ADDRESS 1515 LAFAYETTE AVE.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3-31-63	
23c. NAME OF CEMETERY OR CREMATORY Anatomical Board		23d. LOCATION (City, town, or county) St. Louis, Mo.	
24. Rowland Aker Mortuary Service 4104 Manchester Ave.		25. DATE RECD. BY LOCAL REG. MAR 29 1963	
		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.

If this body is not embalmed, fact should be so stated above.